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Online Report of Army Aircraft Mishaps

The 2011 Aviation Trends (page 3) indicate several problems that Aviation Leaders should be focusing on with their aviators. Overconfidence , complacency, and inadequate mission planning increased from last year. A staggering 88% of Class A mishaps involved overconfidence and complacency. In November, we provided some ideas as to how complacency becomes accepted, and Dr. LeDuc pointed out how this occurs. "You begin to accept lower standards of performance and start pencil whipping those checklists because you know you'll remember to check everything; you've never missed anything before." By looking at last year's Class A mishaps, "everything" was certainly not checked in the end, and the environment judges without compassion.

Inadequate mission planning, specifically - failing to plan for obstacles and management of power requirements, increased in 2011. To provide some thoughts on mission planning, the mitigation strategy starting on page 2 is highlighted in this month's issue. Dr. LeDuc reminds us that our mission approval process continues to be an important mitigation tool. "If you, or someone you work with, are conducting mission planning, you may want to take a second look at that plan and solicit information from the people around you. Granted, it can be tedious, but the preplanning and planning processes require continued focus and objective approaches to prevent a disastrous outcome in the form of an accident and to ensure mission success."

As we review the 1st Quarter FY12 mishap statistics, we are reminded that Leaders and Soldiers need to stay engaged. In the manned category, the overall number for class A - C is down (25 vs 27) from the 1st quarter last year but there has been a spike in Class A's (5 vs 2). 5 of the 9 Class A/B's occurred under NVD. We had four Class B mishaps, the same as from the previous year, and a decrease to 16 Class C mishaps from 21 the previous year. UAS losses are trending slightly down from last year first quarter.

The "Blast from the Past" of 2001 reminds us that these human error trends are nothing new, and that diligence and engagement make a difference. Mission accomplishment is what Leaders always strive to achieve, and must be balanced to ensure the safety of all involved. The primary method of accomplishing this is detailed planning, which includes in-depth rehearsals and everyone's input.

Until next month, fly safe!

LTC Christopher Prather USACR/SC Aviation Director

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Five P's — Prior Planning Prevents Poor Performance

Dr. Patricia LeDuc, Human Factors Director, USACR/SC

Yes, I know — most aviators and aviation mechanics would insist that it really is "The Six P's," but even with that other one edited out, inadequate mission planning for aviators and acceptance of poor norms in maintenance practices are among our top human errors in aviation accidents. While I have never planned a flight mission, I have planned maintenance overhauls and aviation research projects. You would be surprised how much those three activities have in common. In addition to the preparation, execution and after-action review, there is the ever-important planning and preplanning, which is what I want to focus on here.

During the preplanning stage for any of these activities, we develop the goals or tasks we need to achieve in order to fulfill the mission requirements. For aviators, this might involve reconnaissance or reviewing the history of previous missions to learn about the "lay of the land." For a researcher, it might involve reading a bunch of articles on a particular topic. For an aviation mechanic, it could involve studying tech manuals and talking with manufacturing engineers. The purpose of preplanning is to collect data that will help us understand how the mission will be conducted and alert us to any pitfalls that might have happened in previous missions. It is also the phase where documentation begins in case someone has to replace you during a later phase of the mission.

In the planning stage, the availability of resources and issues, such as integration and mission timing, are considered. Contingencies are evaluated. We look at all factors required to ensure a favorable outcome for the mission. It's at this point in the process that the "I-can-handle-it" attitude starts to creep into our planning. One of the things I've noticed from reading our accident reports and reflecting on some of the research projects I have conducted, is that ego can get in the way of good mission planning. If you hear yourself saying or thinking, "I know best," you may be setting yourself and your crew up for failure.

In reality, the best thing you can do during mission planning is involve everyone in the process. Listen to other people's ideas; they may actually have a better one than yours. I can't tell you the number of times one of my research techs said, "Doc, did you know there is an easier, better, faster or more efficient way to do that?" You would be surprised how much tunnel vision you get when you do the same thing over and over. I learned to let my techs explain their point of view and to listen to their suggestions. A different point of view can often give you a fresh perspective on things and save you from making a critical mistake.

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How do you recognize when you aren't using proper mission planning techniques? What pitfalls should you look for? From my perspective, here are a few prime tipoffs:

1. Your approach has been predetermined before the goals are set and all data gathered.
2. Your approach is rigid, inflexible and may not actually be taking reality into consideration.
3. There is an inadequate division of labor causing overload on some personnel.
4. There is no process in place to obtain timely data relating to changes in the situation.
5. You have leaders grandstanding and attempting to take center stage.

We, "research types," have those huge egos too. We believe we are the best and the brightest and we've been known to adopt rigid philosophies about our projects because we're certain our ideas and ways of doing things are infallible. And yes, when we start a project in that frame of mind, we often fall flat on our face and end up having to start over with a more open mind. In most cases though, a bungled research project only wounds our pride, not our teammates.

If you, or someone you work with, are conducting mission planning, you may want to take a second look at that plan and solicit information from the people around you. Granted, it can be tedious, but the preplanning and planning processes require continued focus and objective approaches to prevent a disastrous outcome in the form of an accident and to ensure mission success.

Dr. LeDuc can be contacted at the United States Army Combat Readiness/Safety Center at (334) 255-2233.

Class A – C Mishap Tables

	Manned Aircraft Class A – C Mishap Table									
		FY 11					FY 12			
	Month	Class A Mishaps	Class B Mishaps	Class C Mishaps	Army Fatalities		Class A Mishaps	Class B Mishaps	Class C Mishaps	Army Fatalities
1st Qtr	October	0	1	3			2	1	5	1
	November	0	2	14			1	1	7	0
	December	2	1	4	4		2	2	4	4
2nd Qtr	January	0	0	8					1	
	February	0	2	2						
	March	2	1	5						
3rd Qtr	April	2	1	11						
	May	2	2	2	1					
	June	3	1	3	2					
4th Qtr	July	2	2	9	2					
	August	2	2	9	2					
	September	0	1	5	0					
	Total for Year	15	16	75	11	Year to Date	5	4	17	5

As of 12 Jan 12

UAS Class A – C Mishap Table									
	FY 11 UAS Mishaps					FY 12 UAS Mishaps			
	Class A Mishaps	Class B Mishaps	Class C Mishaps	Total		Class A Mishaps	Class B Mishaps	Class C Mishaps	Total
MQ-1	2		1	3	W/GE				
MQ-5	3		1	4	Hunter		1	2	3
RQ-7	1	11	30	42	Shadow		3	4	7
RQ-11					Raven				
RQ-16A			3	3	T- Hawk				
MQ-18A									
SUAV			1	1	SUAV			2	2
Aerostat	6	9		15	Aerostat				
Total Year	12	20	36	68	Year to Date		4	8	12

As of 12 Jan 12

DES' Evolving Role

CW5 Greg Turberville
Chief of Standards
Directorate of Evaluation and Standardization
U.S. Army Aviation Center of Excellence
Fort Rucker, AL

Over the past decade, the DES role has evolved due to the influences of the Global War on Terror, Army Force Generation (ARFORGEN), Flight School XXI, etc. DES remains relevant and important to the Aviation Branch as a standardization influence for the Commanding General, United States Army Aviation Center of Excellence (USAACE). Recent guidance from the Aviation Branch Commander directed a modification to the DES mission. Replacing the word "assistance" with "assessment" in our mission statement is the fundamental change to the DES mission. To paraphrase, the guidance is to bring the "Big S" back into standardization. This month's article details the evolution of the DES role/tasks as a tool for the commander.

Prior to 2004: DES routinely supported FORSCOM ARMS Teams in conjunction with their resource survey visits to aviation units. The focus of DES involvement was primarily on the overall garrison pre-combat Aircrew Training Plan (ATP). The assistance visit was oriented on evaluating individual Aircrew Training Manual (ATM) base, or 1000-series, aviator tasks. During this time frame, directorate personnel were more representative of the United States Army Aviation Center (USAAVNC) expertise.

From 2004 to November 2011: In addition to directed or requested assistance visits for garrison-based units, DES routinely deployed to combat theaters conducting CAB-level assistance visits. These visits focused on assisting the warfighter by bringing updates to training techniques, new equipment, and branch-level initiative briefings. DES collected tactics, techniques, and procedures (TTPs) throughout these deployment visits to allow cross pollination of lessons learned across theaters and within the Branch (TDA and M/TOE). These deployments allowed combat mission warfighting skill sets and proficiency to be maintained within directorate SME personnel. During this period, DES assistance visits evolved to include a greater percentage of training participation as opposed to purely evaluation. Coincident with this evolution and the ARFORGEN process, DES assisted with programs, such as unit level Individual Readiness Progressions, Combat Maneuvering Flight (CMF), Mobile Training Teams (MTT), New Equipment Fielding and Training (NETT), High Altitude Mountain and Environmental Training (HAMET), Full Authority Digital Electronic Control (FADEC), in order to accelerate the ARFORGEN process and unit readiness during shortened unit dwell cycles.

From November 2011 to Present: New command guidance required a re-focus on assessing the CAB and Battalion/Taskforce ATP during the pre-deployment phase. While DES will and does still include many of the tasks detailed above, the percentage of mission focus during unit visits will trend back towards an assessment philosophy versus an assistance and training philosophy. Assessments are conducted typically at 24 to 36-month intervals, whether requested by CAB commanders or directed by higher headquarters. Assessment visits will be scheduled on CAB timeline and flexible to most ongoing CAB operations. Visits will consist of

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a detailed assessment of the ATP and all associated programs IAW CDR's ATP, ATM, AR 95-1. Aircrews will receive oral, written or flight evaluations to better determine the overall ATP effectiveness. Each BN/TF and CAB commander will receive a findings and observations out-brief following the collective assessment.

During this evolutionary decade, DES continued to participate in key Army-level processes, such as AR, TM, and TC review/rewrite initiatives with appropriate agencies, new equipment fielding, MTT, etc. Likewise, DES provides SME support to the CRC in accident investigation and prevention. And, as always, DES personnel routinely assist 110th Aviation Brigade at Fort Rucker with aircraft qualification courses in all MDSs.

Just as in the past, each SP and ME assigned to DES are fully vetted and their assignment is coordinated through HRC, assuring we incorporate the best of the best to the branches within the directorate. All have the heart of a trainer and come with vast experience and a proven record of performance. Due in large part to the evolutionary experience of the past decade and the new guidance consistent with our mission statement, the old cliché "DES is here to help," truly is the case today, as much as anytime in the history of the DES.

DES Mission Statement

Serves as proponent agency for the Army Aviation Standardization Program for the CG, USAACE. Executes assessments and evaluations of Army Aviation units worldwide in order to achieve standardization of the Army Aviation Aircrew Training Programs (ATP) and all Aviation Standardization Programs. Serves as a direct link between warfighting units and the CG, USAACE, on all matters of the ATP and standardization programs. Provide subject matter expertise to enhance the warfighting commanders' combat readiness. Establish and enforce Army Aviation standardization policies through oversight and staffing of Army Aviation regulations and publications.

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https://safety.army.mil/atf/Home/tabid/1565/Default.aspx

Broken Wing Awards

The Army Aviation Broken Wing Award recognizes aircrew members who demonstrate a high degree of professional skill while recovering an aircraft from an in-flight failure or malfunction, requiring an emergency landing. Requirements for the award are in DA PAM 385-10, Para 6-3f.

CW4 Brian Robinson
CW2 Larry Ciancio
Detachment 33 Operational Support Airlift Command, AASF Buckley AFB, Aurora, CO

At 10,000 feet MSL and 170 KIAS while rolling out from a left 30-degree bank, the C-26E lost aileron control after the aileron control cable snapped. As the aircraft continued to roll to approximately 60 degrees, CW4 Robinson, sitting in the left seat, applied maximum power to the left engine and reduced the right engine to flight idle. He simultaneously applied right rudder in an attempt to stop the airplane from continuing its roll to the left. The airplane responded to the control inputs, stopped the roll rate and leveled. After discovering the right seat pilot, CW2 Ciancio, had at least minimal aileron control, CW4 Robinson decided to transfer the controls after they realized that CW2 Ciancio could control the airplane in roll with generous input of right aileron trim, in conjunction with using counter pressure on the left aileron. CW2 Ciancio handled the controls during the approach and landed the aircraft with minimal to zero aileron control.

CW3 James Hagerty

Task Force Brawler, Forward Operating Base Shank, Afghanistan

While establishing a hover in a UH-60L for a speedball resupply mission, a cardboard box wrapped in plastic flew up from the LZ and entered the No. 2 engine inlet. The crew heard a loud pop, followed immediately by the low rotor audio. From CW3 Hagerty's performance planning, he knew the current conditions negated single engine hover capability. The aircraft began an immediate descent with the rotor drooping to 82 percent. To avoid descending into the rocky pinnacle, CW3 Hagerty chose to maintain collective position rather than reduce collective and attempted to gain forward airspeed. After clearing the rocks, he nosed the aircraft down the side of the mountain to increase airspeed. Once forward airspeed was established, he reduced collective to regain the rotor. CW3 Hagerty decided not to shut off the No. 2 engine as it was supplying 35 percent torque and did not exceed the 10-minute TGT limit for the 6-minute flight back to FOB Shank.

Mr. Vicky Mitchell
A Company, Special Operations Aviation Training Battalion, Fort Campbell, KY

Mr. Mitchell demonstrated extraordinary judgment and skill during helicopter refuel operations on a zero illumination night, utilizing night vision goggles. The refuel drogue on the MC-130 hose failed to disengage from the probe of the receiver aircraft. Subsequently, the hose failed at its attachment point to the pod reel on the MC-130, leaving 95 feet of hose hanging from the refuel probe of the MH-47G. Once the refuel hose tore free, Mr. Mitchell

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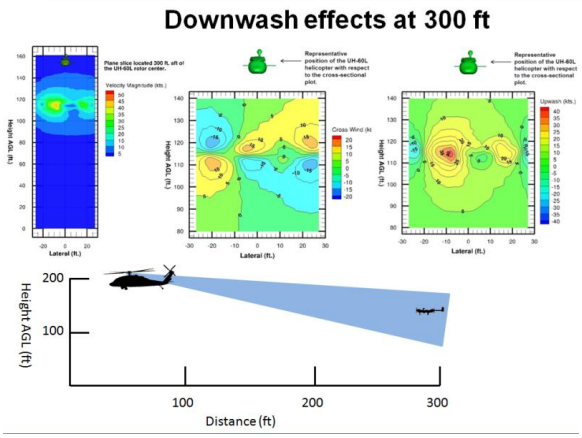
maneuvered the aircraft to avoid the flailing hose from striking the aircraft. Mr. Mitchell then piloted the aircraft to the closest airfield using a shallow approach path and airspeed which kept the hose under the aircraft until he came to a high hover above the airfield. From this point, he began a descent until the hose contacted the ground, then hovered and descended backward laying the hose on the ground in front of him until he touched down.

CW4 Michael Hambrecht
5th Aviation Battalion (P), JRTC and Fort Polk, LA

While at 1500 feet and 90 KTS at night in the OH-58C, the crew experienced a LOW ROTOR light and audio alarm. The pilot on the controls entered a power on autorotation. CW4 Hambrecht confirmed full throttle and verified the PI had not unintentionally decreased the rotor RPM with the GOV RPM switch. During descent, rotor RPM could not be maintained when outside of an autorotative profile. CW4 Hambrecht requested the PI to increase engine RPM using the GOV RPM switch with no effect. With the only suitable landing area behind the aircraft, CW4 Hambrecht turned 180 degrees to the left towards a confined area surrounded by lights which washed out the NVGs, making it difficult to see obstacles in or around the landing area. During descent and already at max glide airspeed, CW4 Hambrecht realized he would be short by approximately 150 feet. At about 75 feet above the trees, with partial power, CW4 Hambrecht pulled the collective momentarily, in conjunction with a very small deceleration maneuver, to extend the glide distance to a point past the tree line. He lowered the collective again and executed a zero ground run landing with no damage to the aircraft.

If you have comments, input, or contributions to Flightfax, feel free to contact the Aviation Directorate, U.S. Army Combat Readiness/Safety Center at com (334) 255-3530; DSN 558

Mishap Review: MQ-5B Hunter UAV



Synopsis

During a night landing, an MQ-5B Hunter Unmanned Aerial Vehicle (UAV) encountered a UH-60L's rotor wash, lost control, and landed hard with significant damage.

History of flight

The UH-60L was conducting an NVG training flight and had been cleared for a practice GPS low approach to runway 24. Concurrently, an MQ-5B Hunter UAV was returning from a mission and entering a north downwind for landing runway 24. While on final and with visual acquisition of the inbound UAV, the crew of the UH-60L determined a potential airspace conflict existed with the UAV and executed two left 180-degree turns for spacing before establishing back inbound on its final approach heading for landing. The MQ-5B Hunter turned final approach directly behind the UH-60L. The UAV encountered rotor wash on short final, resulting in loss of control and a hard landing with Class B damage to the vehicle.

Commentary

It was determined that the UH-60L did not follow the approach clearance instructions issued from the tower. After acquiring the UAV, the PC commanded the PI to turn 180 degrees without amending his approach clearance instructions. Unbeknownst to the PC, the UAV was approximately 3 nautical miles to the north and established in the northern downwind of the traffic pattern. The spacing turns actually decreased the separation between the helicopter and the UAV.

The Board noted that once clearance is accepted, the aviator is required to comply with ATC instructions. The aviator may request a clearance different from that issued if another course of action is more practical or aircraft equipment limitations or other considerations make acceptance of the clearance inadvisable. Aviators should also request clarification or amendment, as appropriate, whenever a clearance is not fully understood or considered unacceptable because of safety of flight. The aviator is responsible for requesting an amended clearance if ATC issues a clearance that would cause an aviator to deviate from a rule or regulation, or place the aircraft in jeopardy.

"Hope" is never a Course of Action (Reprinted from Flightfax, October 2001)

Aviation has proven time and again that it is the most maneuverable and lethal weapons system on today's ever-changing battlefield. During the last several years, Army Aviation has found itself involved in a myriad of atypical missions. Atypical because the mission requested doesn't exactly fit into the unit's Mission Essential Task List (METL). These missions, rather than a one-time requirement, are becoming the "norm." As the force structure continues to shrink, and the mission load continues to grow, aviation units will continually find themselves asked to perform multifaceted, highly complex missions in unfamiliar airspace.

Select aviation units may be the "only show in town," and our inherent capabilities provide a dimension to the battlefield that no other combat arm can produce. And it is because of this complexity and variation that we must stay ever vigilant about mission execution. Leaders must guard against complacency, loss of risk assessment objectivity, or the failure to make risk management a continuous process. There is no substitute for thorough mission planning, detailed rehearsals, and strict adherence to risk reduction and control measures … these things are an aviator's Intelligence Preparation of the Battlefield (IBP) … and you ***MUST*** know your enemy.

Unfortunately, because of our high OPTEMPO, many units are forced to rapidly transition from one complex mission profile to another. Such frequency may cause the atypical missions to be perceived as routine, where unvigilant leaders allow these missions to be treated with less than appropriate planning and oversight.

An analysis of recent mishaps illustrates how shortfalls in the planning process, coupled with the absence of institutionalized risk management and leader involvement, can foster an environment of mission planning complacency. In two cases, the missions involved multi-ship, sling load operations under night vision goggles (NVD) conditions. Coincidentally, these units had successfully executed a number of varied missions in the preceding six months, which may have further contributed to their false sense of security. The units failed to recognize the cumulative effects of risk, and leaders allowed risk reduction decisions to be made at an inappropriate level. Instead, both units relied on prior planning and crew experience to fill in the blanks for basic, thorough, detailed planning and risk assessment. In both cases, the missions were received well in advance, and planning was assigned to junior officers. This was considered adequate because similar scenarios had just been executed without incident weeks earlier. However, we all know that the first step in sound mission planning is to conduct a complete mission analysis (MDMP). Planners must also ensure that all members understand the commander's intent, ground tactical plan, reverse planning sequence, risk assessment, and any control measures/abort criteria that can effect mission execution. This is commonly referred to as the 5 "W" process: who, what, when, where, and why. The "how" is determined by the commander and S-3. Once the plan is set, the aviators must begin their task of thorough mission planning to execute the "how. Finally we must REHEARSE … REHEARSE … REHEARSE to ensure EVERYONE knows their role … NO CONFUSION!

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Unfortunately, this is where these units allowed their false sense of security to fly lead. As stated, these missions were planned as NVG, Air Assault missions into confined LZs or unfamiliar terrain. On one particular mission, the winds were high, the clouds were low, and the rain was heavy. Somewhere in the decision cycle, in a flight of four aircraft flying a staggered right formation, it was determined that the heaviest, least maneuverable (HMMWV sling load) aircraft would fly as Chalk 4 instead of Chalk 1. Additionally, the ingress route was changed at the PZ because of deteriorating weather. This change now required the crews to negotiate a 180-degree right-hand turn to final at the LZ. In a similar incident, a UH-60 unit previously identified a weakness in their ability to execute NVG sling load operations. However, the command elected not to do anything about it, and the mission attempted by an inexperienced flight crew. Subsequent to "brownout" during load pickup, the crew attempted to fly out of the cloud. Instead, they allowed the load to hit the ground, and the Black Hawk ultimately crashed in a right nose-low attitude and rolled across the desert floor. Final result in one incident: six personnel dead, nearly a dozen injured, two UH-60s and one HMMWV completely destroyed. Final result on the second incident: five personnel injured, the aircraft and HMMWV were totally demolished.

In both scenarios, there was little supervision or mentoring during the mission planning process to ensure all facets (risks) of the operation were examined in depth, to identify hazards, and modify courses of action to implement the necessary risk mitigation/reduction controls. Both scenarios evidenced crew overconfidence in their ability to handle situations even as cumulative effects rapidly reduced the margin for error. Decision makers, (senior commanders, unit commanders/SPs/IPs) must remain objective enough to recognize the escalating cumulative effects of a number of seemingly benign individual risks. They are responsible for analyzing continuous feedback from mission focused subordinate leaders in order to identify risks that can adversely affect mission execution. Once the planning process is complete, it is absolutely imperative that every potential branch or sequel is played out and rehearsed. Crews and leaders at all levels must clearly understand the hazards, risks and controls that have been put into place to reduce mission risks. Without a clear understanding of these elements, all participants can't actively recognize and assess changing hazards and the associated increase in risk. A rehearsal is a key vehicle for establishing this common understanding and essential to mission success.

The Center for Army Lessons Learned (CALL) sites rehearsals as highly effective and an excellent tool in risk control and reduction. Moreover, it is fundamentally critical that all mission personnel attend and participate in the rehearsal. That is the time to voice concerns, ask questions, and iron out confusion. The rehearsal must cover all aspects of the mission: staging plan, loading plan, en route plan, landing plan, FARP plan, battle position occupation, screen line establishment … from primary ingress and egress routes, to any reasonably expected or anticipated contingency that may be implemented. It must be clear in everyone's mind exactly what will be required during every phase of the operation, and how outside factors can change mission requirements.

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Blast From The Past continued from previous page

Senior aviators/leaders and crewmembers have a professional, if not moral, responsibility to voice all concerns, real or perceived, anytime their "comfort threshold" is broken. The old adage is true; *"The only stupid question is the one that isn't asked."* Questions must be voiced regardless of the perception; i.e., *"my suggestions are always ignored"* or *"these guys will think I'm dumb"* … well, better dumb than dead!

Mission accomplishment is what we as leaders always strive to achieve. It must be balanced to ensure the safety of all involved. The primary method of accomplishing this is detailed planning, which includes indepth rehearsals and everyone's input. Don't be a shrinking violet. When a point of concern becomes evident, such as deteriorating weather, stand up, be counted, and let your concerns be known. Never allow complacency, or fear of ridicule, determine your actions in and out of the cockpit … or let yourself become the guy that has to look in the mirror and say: *"If only I had said something, they might be alive today."* If you're struggling with the decision to stand up, picture yourself at a memorial service for the crew, or in an interview with the investigation board. Would you be equally convinced or could you justify your actions? And if not, take action — do the right thing! Remember, ***"Hope is never a course of action!"***

Preliminary Loss Reports (PLR)

ARMY PRELIMINARY LOSS REPORT 12026

OH-58D CRASH CLAIMS FOUR SOLDIERS' LIVES

Four 4th Squadron, 6th Cavalry, Fort Lewis, Washington, Soldiers were killed in an accident involving two OH-58D Kiowa Warrior Helicopters on 12 December 2011, at approximately 2000 near community of Rainier. The four pilots (25-year-old CPT, 32-year-old CW3, 36-year-old CW3 and 32-year-old CW2) were conducting routine night training flights when the accident occurred. A Centralized Accident Investigation (CAI) team from the US Army Combat Readiness/Safety Center is investigating. Local News

These four are the **1st** Class A **Flight Accident** fatalities in FY12 compared to **0** for the same time frame in FY11. This PLR does not identify specific root causes of this incident as the investigation is ongoing. Further details will be available at a later date on RMIS (RMIS Login Required).

Preliminary Loss Reports (PLR) are ***For Official Use Only*** and are to provide leaders with awareness of Army loss as we experience it and to point out potential trends that affect our combat readiness.

Our Army depends on you to use these PLRs to help Soldiers understand the impact of decisions made on and off duty.

The U.S. ARMY COMBAT READINESS/SAFETY CENTER is interested in your comments; please click here to provide feedback on the Preliminary Loss Reports (PLR). FAQs and additional resources can be found on the USACR/Safety Center website at https://safety.army.mil

Selected Aircraft Mishap Briefs

Information based on Preliminary reports of aircraft mishaps reported in December 2011.

Observation helicopter

OH-58D 

- Engine overspeed (NP126%/6 sec) occurred during FADEC manual training. Aircraft was landed without further incident. (Class C)

- Two aircraft collided during NVG training missions. Four fatalities. (Class A)

- Engine experienced an overspeed condition (124%/5sec) during MOC run-up. (Class C)

- First round of an HE rocket engagement reportedly fell short, resulting in three injuries to friendly forces. (Class C)

MH-6M 

- Crew experienced debris in the main rotor system during fast-rope training and executed a forced landing. Aircraft touched down hard and sustained damage to the undercarriage, structure and main rotor blades. (Class B)

Attack helicopters

AH-64D 

- Aircraft rotor system contacted and severed the tether to an aerostat. Damage to one main rotor blade tip cap. Balloon was lost. (Class B)

- Crew experienced loss of tail rotor authority during flight, followed by low rotor RPM and generator loss. Aircraft contacted the ground with the left main landing gear, after which it rolled onto its left side. (Class A)

Unmanned Aircraft Systems

RQ-7B 

- Crew received an IG FAIL reading shortly following launch. Recovery chute was unable to be deployed. UA descended to ground contact with damage and was recovered. (Class B)

Fixed Wing

C-12X 

- Crew experienced a # No. 2 engine surge and overtorque during takeoff. (Class C)

U.S. ARMY COMBAT READINESS/SAFETY CENTER

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